Utah Medicaid Payment and Service Delivery Reform

1115 Waiver Request

Public Comments Received and Agency Responses

The Department of Health received excellent suggestions, remarks and commentary from its request for public comments regarding the Utah Medicaid Payment and Service Delivery Reform 1115 Waiver Request. These comments were expressed at two public hearings, and there were also written statements submitted to the Department. These public comments form the basis for the following narrative.

In order to facilitate responses to these comments, the following narrative will adopt a format which presents a comment(s) regarding a specific waiver provision(s) followed by a response.

In many instances, several comments from different sources addressed the same waiver provision(s). Those comments have been consolidated and summarized by topic. Responses will also follow those consolidated comments.

1. Cost Sharing

   Cost sharing comments were frequent and varied. Clients and client advocates expressed significant concerns regarding the proposed cost sharing provisions. These concerns addressed the increased copayment amounts in conjunction with the proposed introduction of an annual deductible. Client advocates believed there should be no increase and no annual deductible. However, if both cost sharing provisions remained, some individuals suggested tiered copayments based on income, or the implementation of a spenddown option that could be used to satisfy the increases and the deductible. Other client advocates aired a desire to have persons with disabilities exempt from copayments and the deductible. On the other hand, some commenters asked for higher copayments for specialized services due to their higher cost. Another copay comment came from a potential Accountable Care Organization (ACO) and requested an actuarially equivalent cost sharing option.

   Response

   These comments must be assessed and evaluated in conjunction with legislative intent reflected in Senate Bill 180, Medicaid Reform. Part of that intent is to help foster an enhanced sense of client responsibility and to engender more client assistance in maintaining the economic viability of the Utah Medicaid program. Accordingly, incurring health care expenses and treating them as spenddown would not necessarily

comport with the intent to foster enhance client awareness or individual responsibility. Incurred expenses can become bad debts for providers, which can result in a heightened sense of frustration, which can lead to reduced access.

Similarly, hoping to engender greater awareness of responsibility and economic viability, modest increases in cost sharing can also promote more equity among individuals who are similarly situated. For example, representatives from a Community Health Center mentioned that they have copayments of $25 for patients who find themselves in the same economic circumstances as Medicaid clients but do not qualify under existing Medicaid eligibility rules.

In an effort to balance client concerns, other public comments and incorporate legislative intent, the Department crafted the proposed cost sharing provisions. Those provisions reflect modest increases which are sensitive to limited client resources, while at the same time considering perspectives that modify dated copay limits and accommodate legislative guidance. Based on this balanced approach, the initial waiver submission should retain the proposed cost sharing provisions, but include a request for actuarially equivalent copayments. As this is currently allowed in another waiver, including this option would provide additional flexibility for any ACO service delivery model.

Although maintaining the cost sharing provisions in the waiver submission, the State will research what changes are required to the State's eligibility system (eREP) in order to implement a tiered copayment schedule based on income. As soon as the information becomes available, the State will assess the feasibility of a tiered system.

Further, and due to public comment, the State added another row to the table showing the ACO Copayment Summary. That line shows no cost sharing for preventive health services.

2. Client Incentives

One reoccurring comment pertained to the uncertainties associated with the absence of prescriptive parameters for client incentives. Clients and advocates expressed a desire to have the waiver specify what the incentives would be, how each would apply to medical care, what mix of incentives would be offered by each plan, and how patients would qualify for the various incentives.

Response

Comments asking for significant details regarding the types and kinds of client incentives arise from a difference in perspective regarding the conceptual framework of the waiver application. The application's perspective seeks to provide potential ACOs with the flexibility to design client incentives that would be most conducive to their service

delivery models. This allows potential providers to design creative initiatives rather than conforming to a single-dimensional model dictated by the State. In addition, this flexibility enhances client choice. Clients can assess which ACO's package of incentives best suits their individual needs.

Although plans have the flexibility to design incentives which facilitate service delivery models, the State will continue to host discussions that will set forth general guidelines and parameters. Previous discussions were useful in receiving client and provider input which facilitated the drafting of the waiver application.

Supporting the approach to maintain ongoing discussions were the positive comments respecting the transparency of the previous process. The Department of Health will maintain that openness throughout the continuing process. That transparent process will help establish general conceptual guidelines.

As to funding, Utah Medicaid anticipates that after approval by federal authorities, incentives and health promotion and prevention activities would be funded through a combination of federal and state dollars.

3. Medical Homes

The same comments concerning the absence of prescriptive parameters for client incentives were also expressed about medical homes. Clients and advocacy groups were fearful that without a set structure or prescriptive definition that the term medical home would be used as a gate keeper or act as a barrier to care.

Response

There are several definitions that are in vogue for medical home. As such, potential providers can design medical home models most conducive to a variety of treatment and service delivery schemes. Similarly, clients can choose which medical home model is most advantageous for them or their families. Under no circumstances will a medical home be a gatekeeper restricting access to care. Provisions to ensure this can be implemented in ACO contracts and are not a necessary waiver issue

As with incentives, plans have the flexibility to design a medical home model which facilitates their service delivery models. However, the State will continue to host discussions that set forth general guidelines and parameters for medical homes, which will ensure basic concepts supporting coordination of managed care.

4. Premium Subsidies

Some individuals and group representatives expressed opposition regarding the client option to choose private sector insurance through subsidized premiums. On the other hand, there were also expressions of support.

Those opposed to the provision cited research that concluded Medicaid provided the best value for the dollars spent. Therefore, why propose an option that has presumably less value? However, a potential ACO and a professional provider organization supported the initiative. Their comments favored a private sector solution as offering the best advantages to both the client and provider.

Other comments included:

- If the option is retained, Medicaid could pay for wrap-around services,
- Premium payments should be paid directly to the employer and not the individual, and
- Employers should pay at least 50% of the premium.

Response

Even though there are mixed feelings concerning this provision, it does offer the client the option of making a choice. Some clients may prefer private sector insurance rather than Medicaid coverage because they could avoid a perceived stigma that accompanies Medicaid coverage, and have access to additional providers. Further, the client would exercise the option only when it makes sense for his or her family situation and preference. As such, the option should be retained in the waiver submission.

As to comments concerning wrap-around services, costs associated with these services could negatively impact the cost neutrality of the waiver. Lacking specific data on the cost associated with those services, caution is a more prudent approach. If, in the future, there is some flexibility or room under cost neutrality, the topic can be reviewed for consideration.

Regarding the comments that the employers pay at least 50% of the premium cost, this provision is already in another waiver and is the expectation of the private insurance covered under this plan as well.

Also, there have been some requests to have the subsidy paid directly to the employer. As this would create additional administrative overhead and expense, and since a similar program currently pays the client for the premium, and it is working well, incurring an additional administrative expense would not be advisable.

5. Benefit Prioritization Process

There have been several reservations expressed concerning the inclusion of a Benefit Prioritization Process. Individuals believe that having such a process and formulating a priority list of services would be tantamount to rationing health care. Adding to the concern is that advocates and providers say that the process lacks clarity. However, some limited support has been offered if a priority process and list were developed through a procedure that has its foundation in evidence-based medicine.

Response

The Department recognizes the value of defining and structuring a process and a priority sequence supported by evidence-based medicine; but it is likewise cognizant of the extensive time and resource commitment. Even if it were possible to have established a process before the July 1, 2011, which was the submission deadline required by Senate Bill 180, CMS has not indicated whether it would entertain such a proposal. If CMS is unwilling to entertain the idea, the expended time and resources would have been for naught. It is more practical to ask CMS if it is willing to entertain and approve the idea before committing time and money to the endeavor.

When establishing a priority process and list, evidence-based medicine would be used as a basis. However, there must be agreement as to the meaning(s) of evidence-based medicine, what constitutes evidence-based medicine, and how the concept would be applied.

Should CMS approve the concept, the Department envisions the same type of process used earlier to obtain input from interested groups and individuals. That process will remain transparent and collaborative. As it previously did, it will include representatives from the provider and client community. This same development practice would also apply to the formulation and implementation of quality assurances measures.

In addition, there is a significant tangential benefit to having such a procedure in place. From time to time, Utah Medicaid has found it necessary to reduce budget and services in order to meet the demands of declining revenue. The decision process associated with the reductions is arduous, stress laden and often divisive. Developing and employing a priority list which is generated and approved through a public process would provide a blueprint should future situations and circumstances dictate.

Furthermore, the statute requires limiting growth to general fund expenditure growth. If ACO system savings do not result as planned in any year, this provision would be required to comply with statute.

The waiver should maintain this provision.

6. Waiver Provision of Amount, Duration and Scope

   Questions have been received regarding limits or restrictions that, if necessary, might be placed on the amount, duration and scope of services. Questions such as, what services, what scope of any given services and what duration of services would be reduced or eliminated in the event of a reduction?

   Response

   There seems to be some confusion as to how limits of amount duration and scope fit within the overall context of the waiver. The provision is an integral part of, and only applies to, the Benefit Prioritization Process. As such, if this priority process is approved, the same open and collaborative environment will be in force to define and structure the conditions relating to amount, duration and scope.

7. Closed ACO Panels and Paying Non-Panel Providers

   A professional provider organization has recommended open panels, any willing provider. This provider group would be willing to accept the same level of reimbursement available to providers who are panel members of any ACO.

   Response

   The Department agrees that adopting a strategy of any willing provider would mean at a minimum that the providers must accept the rates negotiated by the panel members under contract to the ACO. Further, in order for the ACO to ensure the same level of quality, any willing provider would also be subject to the medical practice criteria and quality standards essential to the operation of a particular ACO. Another critical aspect is that any willing provider must also carry the same financial risk incumbent on panel members. Moreover, accepting this strategy could create some financial impacts for the ACO. If ACOs accept any willing provider, it could dilute an ACO's ability to negotiate discounts predicated on the volume of business for its panel members. Reducing the discounts that are based on guaranteeing certain volumes of business could have an adverse impact on costs and savings.

   Based on requests from providers, the waiver will include a statement allowing an ACO the option of having either an open or a closed panel.

8. Providing all Necessary Medical Services

   Client advocates want assurances that all medically necessary services are available through the ACO.

   Response

   All ACOs must provide the services which are included in the contract scope of service. If a particular ACO does not provide a service within the contract scope, it is expected to

procure that service, if necessary. Further, once a capitation payment is made, the ACO can at its discretion make payments to any practitioner for any medically necessary service. Since the present contracting system accounts for and provides for services, the waiver does not necessarily need to include a statement regarding the provision of all medical services.

If due to circumstances, it becomes obligatory to reduce the scope of necessary services, any reduction process would be through the Benefit Prioritization Process. Under that process, the most medically necessary services would be preserved while the least necessary may not.

9. Supplemental Payments, Funding Streams, Rate Calculations

There were several comments and questions concerning rate calculations, supplemental payments, funding streams and cost neutrality. A suggestion was also offered to base Medicaid rate calculations on risk-adjustment models used by CMS in Medicare Advantage plans.

Response

As a result of these inquiries, the calculations in the Cost Neutrality section of the first waiver draft were modified. The modifications were based on provider input. During these discussions with provider groups, there were other clarifications, one of which dealt specifically with funding streams and supplemental payments.

Similarly, there were some adjustments to rate calculations based on Medicaid Eligibility Groups or MEGs. These MEGs are adjusted for the acuity and the intensity of care. Rates paid to ACOs will be based on individual MEGs and will include costs specifically applicable to pharmacy.

10. Enrollment

The initial enrollment provision would have assigned new clients, who express no ACO preference, to the least costly plan. Some provider representatives preferred a rotation or equal distribution scheme. Individuals believed that the equal distribution of enrollees would ensure a sufficient number of clients for each plan to create operational economies of scale which would help spread fixed costs.

Response

During the first year of the waiver, clients will be assigned on a rotational basis. After the first year, data will be available to evaluate each plan on the basis of cost and quality. The metrics on which those judgments are based will be formulated and agreed to by participating providers and other interested stakeholders. Accordingly, after the first

year, new clients who express no preference will be assigned to the plan(s) which has the best quality and the lowest costs. (Assigning clients based on the least costly alternative was a recommendation from a recent legislative performance audit of Medicaid.)

11. Disenrollment

    Some individuals felt that the disenrollment process in the waiver might possibly lead to provider abuse by disenrolling clients who require extensive medical care. They asked for changes and client safeguards to that process.

    Response

    The disenrollment process to which they refer is an integral part of the existing 1915(b) waiver. The disenrollment process is directed specifically at clients who are belligerent, unruly and uncooperative.

    Agency staff explained the intent of the provision and pointed to the fact the provision exists within a current waiver. Staff also explained that the provision has been used rarely in the past. Representatives of prospective accountable care organizations supported and concurred with that analysis.

12. Quality Standards

    There were a number of comments about what would be used to measure the quality of services. Those testifying wanted more clarity and more local agreement on quality standards.

    Response

    In an effort to build a more unified approach, the Medicaid agency agreed to use existing measures (HEDIS and CAHPS) to evaluate performance in the first year of the waiver. During the first year, interested parties would meet to discuss a system of metrics, evaluation organizations and other methods to assess ACO quality performance.

13. Expand Coverage to Long-Term-Care and Behavioral Health

    There were some comments about including long-term-care and behavioral health in the waiver request. Some of those commenting believed that including these two high cost services would facilitate managing the continuum of care for clients. Statements reinforcing this perspective indicated that there was really no differentiation between private duty nursing, home health services and nursing home care because they are all medical and long-term-care services.

    Response

At the present time, there is no immediate plan to include these types of services in this 1115 waiver application. The wavier application is for a demonstration project that already includes several complex aspects. It would seem judicious to begin with an incremental approach and to reserve these services for inclusion at a later date.

Regarding differentiation between categories of service and medical care, there are specific criteria which distinguish what service is provided and to what extent individuals are eligible for a particular service. Yes, it is all medical care, but the types of care depend on the severity of the illness and the most cost effective setting i.e., home health services, private duty nursing and long-term-care services.

As to including mental health services, the State of Utah currently has a waiver that allows clients to receive treatment for mental health conditions from and through each county mental health authority. Funding for these services also comes from these county mental health authorities. Coordination of care between mental health center staff and physical medicine providers is a significant and important aspect of the total patient care.

14. Consumer Protection

Client advocates asked for various panels or additional committees which would ensure consumer protection and provide additional oversight.

Response

Utah Medicaid meets the federal requirements for client safeguards. Central to those safeguards is the administrative hearing process. In addition, the Medical Care Advisory Committee also affords an avenue for client protection. Further oversight is provided by various federal agencies and audit groups, e.g., the Medicaid Integrity Group and the Payment Error Rate Measurement process. In addition, the State of Utah has an Office of the Inspector General for Medicaid. Furthermore, a waiver provision would not be required to form additional committees. The Department has, however, determined it would like to convene a quality assurance advisory group to help develop new quality measures as the ACO reform evolves.

15. Nutrition Counseling

A suggestion was presented to include nutritional counseling as a separately identifiable service. The comment indicated that there are several advantages and benefits to including this service.

Response

In managing client care, the ACO can include nutritional counseling in its range of services. It would also be in the ACO's best interest to provide the service if required.

(Currently, the Department does provide nutritional counseling for individuals with diabetes.)

16. Antitrust Implications

Hospital and physician representatives expressed significant concerns about possible antitrust implications. These concerns focus on collaborative negotiations dealing with the pricing of services, the sharing of risk and the distribution of savings.

Response

As this requires a legal review, Utah requests that the recent accommodations extended under Medicare ACO provisions apply to Utah's proposal. In addition, we would ask CMS to coordinate with the Department of Justice (DOJ) and grant assurances that the "rule of reason" applies in any analysis undertaken by either CMS or DOJ. Finally, we would ask that CMS provide guidance.

17. Additional Provisions and Assurances

A large provider organization identified areas, items, and issues which it would like included in the waiver. The association would also like CMS endorsements as a condition of waiver approval. Those items are briefly identified below:

a. Negotiations to determine what providers will be paid and compulsory provisions to ensure ACOs provide fair compensation.
b. Mandatory inclusion in discussions defining and structuring medical homes.
c. Appropriate adjustments in rates for increased care requirements.
d. Agreement by providers as to what constitutes patient outcomes and quality.
e. Requirements that ensure ACOs will pay incentives to providers that generate cost savings that foster innovation.

Response

The waiver application is primarily a conceptual document that sets forth parameters under which the waiver will be administered and operated. To facilitate communication and understanding between the State and CMS, many of the characteristics of this application are covered by a CMS 1915(b) preprint. The preprint is a CMS document which has features that apply to this 1115 request. Accordingly, Utah Medicaid has used this preprint to save time and to facilitate waiver approval. As the preprint is part of the conceptual design, it does not contain details relating to administration and operations. The details are more appropriately included in contract provisions between ACOs and providers. Issues that relate to rates, rate adjustments, quality and patient outcomes, etc., are more suitably handled during contract negotiations and in contract provisions. The resulting contracts must go forward to CMS for its review and approval.

As for participation in any future determination of the definition of a medical home, the Department envisions the same type of process used earlier to obtain input from interested groups and providers. That process will remain transparent and collaborative. This also applies to the formulation and implementation of quality assurances measures as well as to other issues.

Accordingly, Medicaid should continue with the waiver application and rely primarily on the contract negotiating process to resolve these types of contractual issues.

18. Payment to Hospitals

A physician representative cited a provision relating to ACO qualifying criteria. Part of those criteria state that the plan or ACO must pay 70% of an inpatient stay after the deductible. The physician group would like to tie this requirement to physician reimbursement.

Response

The language referred to is part of an existing 1115 waiver that is applicable to the Utah Medicaid Premium Assistance Program, and thus applicable to the premium subsidy in that waiver. As such, the language refers to the maximum amount of copay which can be charged to the client. The meaning is simply that the plan must pay 70% of the cost and cannot charge the client more than a 30% copayment. As such, this provision is not applicable to the overall reimbursement calculations associated with cost neutrality in this 1115 ACO waiver request.

19. ACO Enrollees with Special Health Care Needs

In addition to existing methods to identify special health care needs, some of those commenting would like to include other mechanisms or professionals to ascertain, identify and treat individuals with special health care needs.

Response

Existing health plan contracts include such provisions. The ACO contracts will include the same requirements. In addition, the Medicaid agency relies on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to identify and furnish guidance for the treatment of individuals with special health care needs. EPSDT includes a referral program which is used to refer clients to specialists who can meet those needs. It would also be in the best interest of an ACO with a medical home to identify and treat individuals with particular needs, meeting those needs constitutes cost effective care.

20. Stop-Loss, Risk Corridors, Reinsurance, and Penalties for Efficiencies

A potential ACO contract representative suggested the waiver include provisions for stop-loss, risk corridors, reinsurance and protections against rate reductions due to efficiencies.

Response

To provide for a stop-loss provision and risk corridors would significantly impact the premise on which this demonstration project is based. These payment methods have been used in the past and did not achieve the desired outcomes. There were also issues associated with the application and calculations of stop-loss and risk corridors which served to complicate ongoing operations. Accordingly, paying a PMPM grant with the expectation of improved quality and outcomes is not in concert with constructing a stop-loss mechanism or a risk corridor as backstops for contractors.

As to reinsurance, it is a common practice in the private sector to obtain reinsurance. At the ACO's option, it can purchase reinsurance if in the contractor's judgment it makes good business sense.

Regarding the potential reduction in rates due to efficiencies, the text of the application clearly states the intention to maintain the current level of reimbursement. In addition, it is a reasonable expectation that due to improved outcomes and lower costs based on innovations that resulting savings are retained by the contractor for distribution to panel members. To do otherwise would not changes the reimbursement incentives on which this demonstration project is based.

21. CMS Perspective, Access to the Restricted Account, and the Hospital Assessment

One individual furnished commentary concerning the lack of sensitivity by CMS to local comments and perspectives. The same commenter suggested changes relating to the current provider assessment and more expeditious access to the Restricted Account.

Response

As the remarks regarding CMS were in the form of commentary, these comments are beyond the purview of the waiver.

22. PCN Waiver and Associated Costs

One comment was in the form of a statement followed by a question:
The waiver states that PCN patients will be required to enroll in ACOs, but their costs are excluded from the cost-effectiveness calculation for the waiver. What does that mean and how will it be handled?

Response

This issue pertains primarily to how CMS tracks federal expenditures by waiver. The statement above refers to Non-Traditional Medicaid clients that receive coverage through the PCN waiver. The costs associated with these clients are accounted for under the PCN waiver to avoid double counting those costs in this ACO waiver request. These clients will be required to obtain services from an ACO but will continue to have the cost associated with those services recognized in the PCN waiver.

23. Reimbursement, Expenditures and Appropriate Costs

A representative from a provider organization expressed concern about the most appropriate care at the lowest cost. The commenter believed that rather than a reference to the lowest cost, the wording should be the lowest appropriate cost. Continuing with a similar thought, the individual believed that payors should not be determining the "best services."

Response

The conceptual waiver design creates a service delivery model that fosters a collaborative and holistic approach. It is to the ACO's advantage and its panel of providers to furnish the most appropriate care for to do otherwise will be more costly. Details concerning this holistic approach are best defined and determined during contract negotiations.

24. Revenue and SB 180, Medicaid Reform

Another statement dealt with tying increased medical expenditures to general fund appropriations and not to needed services, inferring that the needs should dictate the appropriation.

Response

SB 180, Medicaid Reform, is now in statute and ties medical funding to increases in State revenue and appropriation. The waiver abides by the intent and direction of the legislation.

25. Rate Setting and Lifestyle Choice

Another comment wanted the rate setting methodology and scope of service coverage to consider medical problems created due to life style choices.

Response

Actuarial certification takes into consideration all illnesses and associated treatment costs regardless of cause. Accordingly, treatment costs and illnesses are reflected in the rate setting process. This might be an area in which an ACO may wish to apply incentives.

26. Reimbursement and Payment Strategy

An association would like the waiver to mandate ACO payments to physicians for creating cost saving incentives for innovations in care and for quality outcomes.

Response

Based upon the waiver concept and its provisions, this type of issue is better addressed during contract negotiation between medical providers and contractors.

27. Additional Payments Based on Unexpected Healthcare Services

Another suggestion pertained to mandating additional ACO payments to providers for unexpected healthcare services necessary to treat a patient. "If this is not a consideration, cost will continue to be higher because physicians will refer those patients to emergency rooms rather than handling the care themselves."

Response

The waiver's design creates an environment in which it is in the best financial interest of an ACO to provide quality services through its providers at the level of lowest costs. If patients are referred to emergency rooms for treatment, the payment for that service will be much higher than it would otherwise be. As such, this would lend itself to be more of a contractual issue than a waiver design issue.

28. Supplemental Payments and Other Provider Reimbursement

Currently, all supplemental payments go directly to hospitals. Other providers would like a portion of those supplement payments. These payments include: Disproportionate Hospital Payments (DSH), Graduate Medical Education Payments (GME), and Indirect Medical Education (IME).

Response

Supplemental payments are based upon very specific costs associated with circumstances and situations dictated by federal requirements. To carve-out a portion of those payments to enhance other provider reimbursement would not be in concert with federal requirements and legislation.

29. Continuous 12-Month Eligibility

There were some individuals who for the sake of administrative efficiency and better continuity of care suggested a 12-month period of continuous eligibility.

Response

This suggestion is beyond the scope of the waiver request as it reflects an expansion of Medicaid coverage.

30. Alternative Sources of Federal Matching Funds

A comment from the provider community requested that the waiver include a provision allowing increases in assessments or new assessments to either offset reductions in legislative funding or as a source of increased funding.

Response

Offsetting legislative reductions or augmenting legislative appropriations through increasing assessments is a matter of public policy. Matters of public policy are best decided through the legislative and executive process of interaction.

31. California Waiver Provisions

There have been some requests to include various provisions of the recent California waiver within Utah's waiver application. These requests have been predicated on what appear to be advantages that might benefit Utah.

Response

The design of the current waiver application was based upon the guidance contained in S.B. 180. Due to the limited time prescribed in statute to prepare and submit the waiver, it could not include all items which might be considered. This idea should be considered on its own merits in a separate policy review.

32. Providing Capital Investments to Modify the Service Delivery System

There were suggestions that the State provide support for the upfront investments necessary to successfully transform the service delivery system.

Response

This suggestion may also relate to some aspects in the California waiver. Accordingly, I would refer the reader to the response in item 31 above.

In addition, providing public funds for private capital investments would seem to be a matter of public policy, which would necessitate the involvement of additional state policy makers.

33. Opting Out of the Premium Subsidy Program

Some individuals expressed a desire that clients be allowed the discretion to opt out of the Premium Subsidy program at any time.

Response

Individuals will be allowed to opt out of the Premium Subsidy program at any time without penalty. Individuals who opt out will be immediately enrolled in the fee-for-service market. They will be required to enroll in an ACO at the next open enrollment period.

34. Disease Management and ACO

    Representatives from potential ACOs would prefer the flexibility to provide disease management services and to expand the option beyond the chronic diseases.

    Response

    The waiver was amended to allow ACOs to provide disease management for not only chronic diseases, but to other diseases. However, the current hemophilia disease management contract will remain in force. Individuals having this chronic condition will be required to select an ACO, but their disease management, and drugs associated with the condition, will remain with the current contractor.

35. Service Exclusions from the ACO Scope of Service

    Provider representatives requested clarification as to specific service exclusions under the ACO scope of services. The representatives specifically mentioned: chiropractic, emergency transportation and non-emergency transportation services.

    Response

    Clarification was provided confirming that chiropractic services, emergency and non-emergency transportation services were carve-outs of the ACO the scope of service.

36. Preventive Services

    Potential ACO providers wanted reassurance that they could provide preventive services even though not specifically stated in the waiver application.

    Response

    Realizing that preventive services can forestall expensive costs associated with treatment, the Medicaid agency affirmed a provider's ability to furnish preventive services although not specifically mentioned in the waiver document.

37. Premium Assistance, Qualified Health Plan Criteria

    In addition to the existing criteria for qualifying plans under the premium assistance program, individuals also wanted to add outpatient surgical services.

Response

The waiver application was modified to include outpatient surgical services in the criteria for qualifying plans under the premium assistance program. Further, emergency service was also added to the criteria.

38. Participation by Dual Eligibles

There was a comment seeking to limit participation of Medicare fee-for-service enrollees in ACOs. Any transition of these individuals into the waiver would be contingent upon an arrangement allowing ACOs to capture a portion of the Medicare savings for these enrollees.

Response

As these individuals are currently enrolled in the existing 1915(b) waiver, and since the Medicaid agency is using a significant part of that waiver to define and operate the anticipated 1115 waiver, these individuals will continue to be included.

39. Furnishing Income Information for Determining Copayments

One individual believed that in order to properly administer copayments, ACOs needed up-to-date eligibility information, and that the State should supply the necessary data.

Response

The State is currently furnishing this information and would make it available to any ACO through a contract and through a business associate agreement.

40. Proposed Elimination of the Service Priority Subsection.

One large provider organization recommended the elimination of subsection J (Service Priority) of Part 1 (Program Overview) in Section II (Proposed Health Care Delivery System).

Response

Subsection J deals specifically with the prioritization of services and the limiting of amount duration and scope. As this subsection is an integral feature of the overall conceptual design of the waiver, it remained in the waiver application. Reinforcing its retention was the support for the concept if it were based on evidence-based medicine.

41. Outpatient Hospital Reimbursement

A suggestion was made to adopt a different reimbursement methodology for outpatient hospital services, or modify the current system.

Response

In compliance with legislative intent, the Medicaid agency is currently working on the implementation of a prospective payment system for outpatient services. Accordingly, implementation will continue with the new methodology.

42. Transition Plan

There were questions about how Medicaid would transition from its current configuration to the new ACO model.

Response

Transition and implementation plans are situationally dependent. For example, if a large medical provider currently serving Utah Medicaid clients qualifies and desires to be a Medicaid ACO, that transition will be different from an out of state provider who desires to enter the Utah market. Rather than try and formulate transition scenarios for widely varying possibilities, transition plans will be formulated to accommodate the most likely possibilities based upon how situations and circumstances develop. However, it is anticipated that many aspects currently in the enrollment process and other operational processes will not vary significantly under the new model. Again, developing those plans will be a matter of transparency and public process.

43. Electronic Medical Records and Medical Information Sharing

A comment was offered that Medicaid ACOs be permitted to share medical history upon enrollment of a beneficiary as a matter of course, i.e. the patient is presumed to have automatically opted in. However, if necessary to gain approval of this provision from CMS, the waiver could contain a provision that allows the beneficiary to opt out of this requirement.

Response

The electronic sharing of individual Medicaid medical information is part of a much larger issue that is currently being debated and discussed on a local and national level. Until that issue is resolved as a matter of local or national public policy, it may appear presumptuous for Utah Medicaid to unilaterally request and implement a plan of tacit consent regarding the sharing of individual medical information.

44. ACO Scope of Service and Services Eligible for Copayments

There was a comment that although the ACO scope of service did not include selective services, those excluded services were included in the table of copayments, which was interpreted to imply that services requiring copayments were also in the ACO scope of services.

Response

There are services that are excluded from the ACO scope of benefits. However, in some instances these excluded services would nevertheless require a copayment. Accordingly, the services requiring cost sharing are not necessarily part of the service package for an ACO.

45. Delivery Systems and Mandatory Services

Another remark concerned the confusion which appeared to exist in Section II, Part 1 of Subsection C1 (Delivery Systems). The comment was that the statement contained in this subsection defines the scope of the ACO contract as being any three or more mandatory services in section 1905(a) and was not consistent with the scope of services shown elsewhere in the document.

Response

The statement referenced above reads as follows: "Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a) , ***or any three or more mandatory services in that section.***" The statement implies an either or selection. Accordingly, the State has chosen to select a scope of service in concert with inpatient hospital services and any other mandatory State plan service in section 1905(a). The phase "any three or more mandatory services in that section," was deleted from the waiver application.

46. Enrollees With Less Than Three Months of Eligibility

A commenter asked for clarification as to whether or not clients with less than three months of eligibility would be excluded from ACO enrollment. Statements made by Department representatives indicated that enrollees who fall into this category would not be included. However, the 1915(b) preprint showed that they would.

Response

The statement in the preprint had not been "checked" indicating that three month enrollees would be excluded. The block showing the exclusion was "checked" prior to submitting the waiver.

47. Changing the Scope of Benefits

Another request was made for clarification as to when and how often ACOs could change their benefit packages. Within the same context, the commenter wanted to know if multiple plans were allowed, such as high options and low options. An explanation was requested regarding actuarial equivalent differences in benefit designs.

Response

ACOs will be required to provide state plan services, with certain exceptions, and any other benefit or service which they care to manage and which supports their service delivery model.

48. Enrollee Cost Sharing and Limitation Applicable to Specific Services

There was one assumption that the table showing enrollee cost sharing was intended to also show service limitations applicable to various services, i.e., physician visits, physical therapy visits, etc. The comment further requested that all service limitations be spelled-out in the waiver application.

Response

The table is intended to show only cost sharing. As to service limitations, they are not part of the waiver's conceptual design. Reimbursement methodology and strategies are now structured and focused on improving the quality of outcomes.

49. Marketing Contradiction

One individual cited what was an apparent contradiction as to whether or not marketing was allowed by ACOs. He referred to an item in the preprint which had been marked as allowing marketing. However, in the same section there was a statement which said the State would not permit direct or indirect marketing.

Response

Under very limited circumstances, the federal government allows a plan to market or advertize. The State of Utah conforms to those federal requirements. However, the State does not allow any other types or forms of marketing beyond that federal authorization.

50. Health Plan Exemption Committee

On rare occasions individuals with unusual needs are exempt from enrolling in a plan. An individual requested physician representation on the exemption committee.

Response

The State Medicaid agency agrees to have continued physician representation on the exemption committee.

51. Monitoring Plan and Results

One person raised some questions dealing with ACO quality monitoring and asked for additional information. These questions were specific to reporting responsibilities, and also completing supplementary information in the Summary Chart of Monitoring Activities.

Response

In the Summary Chart of Monitoring Activities there are various cells. Each cell reflects a quality monitoring responsibility. When "ACO" is shown in a cell, the ACO is responsible for that monitoring activity. Further, the ACO is required to report to the State and the quality assessment agency the activities and results applicable to that cell. (The agency also added NA to cells when applicable.)

52. Slowing Down the Process

One individual requested that Utah slow down the process of waiver submission in order to address all concerns, solve problems and to build consensus.

Response

SB 180 was enrolled on March 15, 2011. The bill mandated that the waiver be submitted to CMS by July 1, 2011. Before the waiver could be submitted, there was also a federally required public notice period of no less than 30 days. If the State had missed the statutory deadline, the Medicaid agency would have been in violation of State law. Although slowing down the process to address all questions and build greater consensus may have accommodated and further clarified some aspects of the waiver application, it would not have been conducive to meeting the statutory deadline.

53. Defects in the ACO Model

There were comments which focused on the model's inability to solve all aspects of the health care crisis. These comments mentioned: lifestyle choices, a shortage of providers, nonexistent patient-provider relationships, exaggerated claims that all providers are dishonest, and that the history of managed care is fraught with failure.

Response

It is not likely that one model contains all solutions. However, the proposed ACO-based approach allows the State an opportunity to explore opportunities to improve quality and control cost growth.

Although past initiatives have met with varying degrees of success, using experience from the past, this initiative can capitalize on lessons learned.

54. Health Home Model

Another commenter wanted the waiver to include a health home model as well a medical home model. This person believed it would be advantageous if Utah had both a medical home model and the health home model in anticipation of the influx of Medicaid consumers in 2014.

Response

All ACOs that participate in the 1115 waiver can create medical home models or health home models or a hybrid or combination of both. Utah's waiver seeks to create an environment to facilitate private sector innovation to solve health care issues. The State will facilitate this innovation through forums which establish guiding principles for medical home models/health home models, but will not dictate prescriptive parameters which may impinge and unduly restrict creativity. Further, ACOs with competing models will also enhance client choice.

55. Full EPSDT Benefits & Medicaid Cost Sharing with Premium Subsides

If the premium subsidy option remains, people expressed a desire to have the program include full EPSDT benefits and to limit copayments to Medicaid limits.

Response

If CMS allows a premium subsidy option, the Medicaid agency would be interested in exploring what flexibility might exist for full EPSDT benefits and restricting cost sharing to Medicaid limits. However, providing full wrap-around services could have an adverse impact on cost neutrality requirements and is administratively complex. In addition, a client would only select the subsidized option if in the client's judgment it makes sense for his or her personal or family situation and circumstance.

56. FQHC/CHC, Medical Home, Reimbursement, and Incentives

An association of Federally Qualified Health Centers (FQHC) and Community Health Centers (CHC) had several comments. With the exception of three comments, their other issues are addressed in various responses. However, their unique comments are:

a. FQHC/CHC providers believe that they are uniquely positioned to provide medical home services to clients. As ACOs are required to contract with at least one center, these centers would make excellent medical homes serving ACO clients. This is especially true for individuals who lose and then again qualify for Medicaid. The centers receive grants whereby those losing eligibility can continue to get services. When and if re-qualifying under Medicaid, there would be no gap in the continuity of care.

b. In addition, these centers are protected by federal requirements dictating reimbursement that must meet their costs. The centers are interested in retaining Medicaid reimbursement that meets allowable costs.

c. Centers also would like to see client incentives in the form of vouchers for non-covered services such as adult dental.

Response

ACOs are required to contract with at least one center. An ACO would also be at liberty to contract with more than one center if the service model accommodates that type of structure. Accordingly, a center(s) could be a medical home for the coordination of care. This would be a contract matter between the center(s) and the ACO.

As for reimbursement, Medicaid contracts with ACOs will stipulate that they are required to pay comparable rates to FQHC/CHC as the ACO pays for similar services to other providers. Further, any allowable costs that are found as a result of an annual cost settlement process, which are not covered by the comparable rates, the difference will be reimbursed by the Medicaid agency.

Regarding incentives which incorporate vouchers for non covered services, this can be a topic of discussion with focus groups. (See #2, Client Incentives) Since the concept of incentives is limited by funding, program structure and operation will be extremely important. Federal regulations and approval will also be a significant factor in determining the viability of this option.

Concluding Statement

This document reflects the public comments received as of the close of business on June 20, 2011. This document also constitutes the agency's responses to those comments. It is anticipated that as the process progresses, additional comments will be provided, along with further responses.